What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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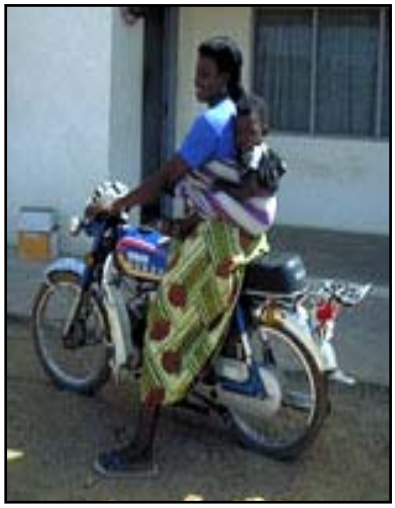
VIEW FROM THE 'FRONT LINE'

The retraining and transformation of nurses into Community Health Officers (CHO) and their transfer from expensive, overstaffed, underutilized, and inaccessible sub-district health clinics to purposely built residential Community Health Compounds (CHC) (at the doorsteps of their rural communities) lies at the heart of new efforts by the Ghanaian Ministry of Health to win the battle to provide, '…adequate, efficient and equitable Primary Health Care Services to all Ghanaians'. CHO are the 'front line' staff in this daunting and difficult 'battle'.



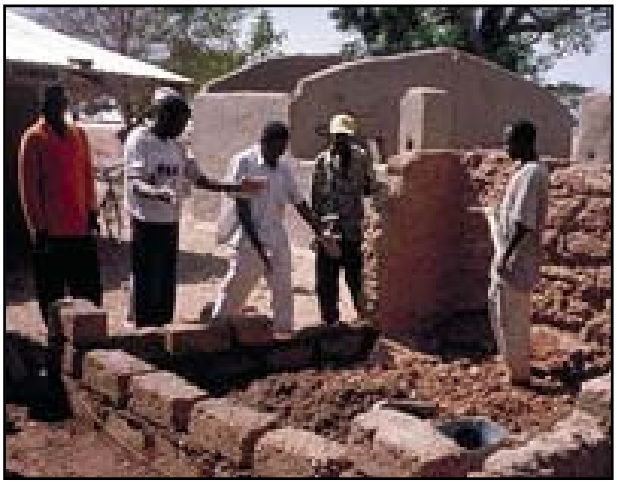
Daycare on wheels

The Navrongo Community Health and Family Planning Project (CHFP) was designed to investigate the fertility and mortality impact of mobilising two sets of resources for the promotion of primary health care (PHC). The first, the 'Health at Every Doorstep Dimension' is concerned with bringing CHO into communities, while the second, the '*Zurugelu* (togetherness) Dimension' entails the mobilization of the rich and diverse local 'cultural' resources, (chieftaincy structure, social networks, community conventions, volunteer arrangements, etc.).

What is the front-line view of the battle and what lessons have been learned from the experiences of the CHO under the Navrongo Community Health and Family Planning Project? *What works? What fails?*

What works?

Autonomy and confidence. Community Health Nurses provide on-site, situational, health care to the communities under their charge. There is ample evidence to suggest that the greater responsibilities demanded of these CHO—as they work independently and in tune with their local contexts—have translated into a sense of greater autonomy, confidence and professional worth. One CHO was recently cited as saying, 'Now I can do things by myself. I don't go to someone to ask (for advice). Now I do things without panicking. I have built a lot of confidence'.



Village volunteers constructing a CHC

Situation and relevance. CHO are trained to conduct situational analyses of the conditions that they encounter during their daily rounds and to respond to immediate circumstances. It would appear that CHO welcome the relevant and timely nature of their interventions. One young CHO for example, said that during her training as a sub-district nurse, and throughout her initial posting at a MCH clinic, new mothers would come to the clinic well dressed, in expensive new clothes, presenting an aura of relative affluence. The nurses would then give detailed talks on nutrition using visual aids depicting fish and other comparatively expensive sources of protein. Now that the nurses are working in the homes of their patients they see that the women are poor and can't afford fish so CHO can advise them on what to eat based upon the resources at hand.

Supervision and support. All CHO are assigned to—and visited by—a supervisor who periodically appraises technical skills, takes note of welfare concerns and keeps a log of the condition of CHC and motorcycles. The supervisory process is welcomed by the CHO as the supervisors offer support and counseling on a range of professional and personal issues.

What fails?

The importance of social distance. At the pilot stage of the CHFP, there was a view that building upon the strong support of chiefs and elders could be formalized by placing the CHC in close proximity to the chief's compound. Some chiefs were eager to help by providing land for construction and even materials for the project. Also, there was a view that having a CHO who was originally from the village where she worked would strengthen the project, since she would know families and feel comfortable

with this new role. Both initiatives failed: Both men and women objected to the idea that chiefs would know about family planning services or possibly be in a position of knowing who was seeking health care. Moreover, nurses who were too close to the village socially could not be trusted to keep secrets. An element of social distance was sought whereby CHC would be constructed in a setting not closely linked with community leaders and CHO would be trusted outsiders.

CHC: construction and location. The most widespread criticism made by the CHO themselves (of their front-line situation) concerns the condition and location of their CHC. The local building materials used to construct the compounds (built as they are by the communities themselves using meagre resources) are not durable and the compounds frequently suffer structural damage, particularly in the rainy season. The comfort and safety of CHO is therefore being jeopardised. One CHO noted that, 'some [compounds] are falling down' and another commented that, 'our lives are at risk'. A further complaint concerned the location of the CHC and the isolated positioning of some, far from the communities they serve. Several nurses expressed the view that they feel lonely and vulnerable to attack. 'You are sleeping in the community alone'. 'Imagine if something happens. You will just be crying alone and no one will come'! This sense of isolation was noted by one CHO when she said that initially when they moved into their CHC they, 'were given wireless sets to stop [them] from being too bored'. Some of these radios had broken down and had not been replaced. As a result the CHO said that they feel like they are 'cut off from the world, not even [just] the country…so [they] don't know if [they] are going to heaven or hell'!

CHO supervisory session

Workload and welfare worries. The Community Health and Family Planning Project (CHFP) has identified the 'domestic problems of the nurses' as one of the eight challenges faced by the experiment. The daily workload of a CHO is intense. It is not uncommon to hear the nurses suggest that two CHO were required to staff each CHC. As one nurse stated, 'when you return from compound visits your bench is full! One [CHO] [ought to] be taking care of the patients at the CHC while the other is on her compound visits'. A CHO supervisor noted that the workload is such that the nurses don't even get a chance 'to breathe'. The supervisor identified a range of potentially serious welfare issues faced by CHO: because of their intense workloads some don't have time to cook in the evenings and have been knows to fall sick and even show signs of malnourishment; access to potable water is another basic problem as they are often in isolated locations far from sources of safe water; if they are married then there are issues over the care of their children as well as their husband's acceptance of their profession; some of them start dressing like members of the community and stop wearing their uniforms, therefore making it difficult for them to be identified as nurses.

Community fatigue. As part of their routine work, CHO complete detailed registers, on the health of women of reproductive ages and children under the age of two, within their catchment areas. These registers require the cooperation and time of members of the community. There is some evidence to suggest that this frequent questioning is fatiguing some communities and leaving the nurses frustrated in their daily rounds. As several CHO remarked, 'some families welcome us and some claim that we are worrying them'! 'They feel that we are wasting their time'. 'Even during compound visits some are fed up with us—everyday the same questions! In the rainy season they are busy farming so if they see a motorbike they walk away'!

Practical problems. CHO require greater access to and regularity of supply of basic medical equipment. CHO complain that 'First Aid' kits containing bandages, gauze, etc. were not available to them for the treatment of minor injuries. As a result they had to turn down clients and send them to other medical establishments for the most basic of treatments. CHO also did not have facilities for the disposal of used injections, as they had not been supplied with incineration kits.

Conclusion

Evidence from the Navrongo experience suggests that the 'front line of the battle' (to provide basic primary health care) is a challenging, harsh and sometimes isolating place. However, being on the front line appears to impart a sense of professional and personal achievement, gained from the knowledge that the battle is being valiantly and appropriately fought. Nevertheless, more concerted and intense efforts ought to be directed into ensuring that the basic welfare needs and technical requirements of the fighters are being met.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, is hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.